1594 West North Temple, Suite 2110, Box 146301, Salt Lake City, Utah 84114-6301 • (801) 538-4700

FISHING LICENSE APPLICATION FOR A PERSON WHO IS HANDICAPPED

(Do not photocopy form)

Attention: False, inaccurate, or misleading information on this application is a **criminal offense** and **violation** of Utah Code Title 23 Chapter 19 Section 5

Utah Code Annotated, Section 23-19-36 provides:
A *resident* who is blind, paraplegic or otherwise permanently disabled so as to be permanently confined to a wheelchair or the use of crutches, or who has lost either or both lower extremities, may receive a free license to fish upon furnishing satisfactory proof of this fact to the Division of Wildlife Resources.

R657-12-2 defines “crutches” means a staff or support designed to fit under or attach to each arm, including a walker, which improve a permanent physical injury or disability.

R657-12-2 defines "Loss of either or both lower extremities" means the permanent loss of use or the physical loss of one or both legs or a part of either or both legs which severely impedes a person's mobility.

Fishing license is issued upon approval of application.

I HEREBY APPLY FOR A DISABLED FISHING LICENSE IN ACCORDANCE WITH THE ABOVE STIPULATIONS

Customer Identification #_____

Name _____ Phone Number_____

Address _____ _____ Utah _____
(Street) (City) (Zip Code)

Date of Birth _____ Gender _____ Weight _____ Height_____

Eye Color _____ Hair Color _____

As the person who prepared this application, I declare under the penalty of perjury that to the best of my knowledge the information provided in this application is true and correct, and that the applicant under all prevailing laws and statutes qualifies to apply for and possess this license.

☐ **As the applicant I have read and understand the requirements for obtaining this fishing license**

_____

Applicant Signature Date

If the handicap is not visually apparent, current documentation from a physician must be submitted with this form. Please complete the physician's statement on company letterhead or form, which identifies the physician's business/affiliation.

`

PHYSICIAN'S STATEMENT

(Must be completed and signed by physician for physical disabilities other than blindness; or by a physician, ophthalmologist, or optometrist for vision disabilities)

I hereby certify the above named applicant meets the criteria of is blind, paraplegic or otherwise permanently disabled so as to be permanently confined to a wheelchair or the use of crutches, or who has lost either or both lower extremities.

1. The applicant is blind?: ❑ **Yes** **No** ❑

"Blind" means the person has no more than 20/200 visual acuity in the better eye when corrected; or has, in the case of better than 20/200 central vision, a restriction of the field of vision in the better eye which subtends an angle of vision 20 degrees or less.

2. The applicant is paraplegic?: ❑ **Yes** **No** ❑

3. The applicant is quadriplegic?: ❑ **Yes** **No** ❑

4. The applicant's physical impairment is Permanent?: ❑ **Yes** **No** ❑

5. This physical impairment permanently confines the applicant to the use of crutches, or a wheelchair?: ❑ **Yes** **No** ❑

"Crutches" means a staff or support designed to fit under or attach to each arm, including a walker, which improve a person's mobility that is otherwise severely restricted by a permanent physical injury or disability.

6. This physical impairment involves the permanent loss of use of at least one of the applicant's lower extremities?:
❑ **Yes** **No** ❑

"Loss of either or both lower extremities" means the permanent loss of use or the physical loss of one or both legs or a part of either or both legs which severely impedes a person's mobility.

Please explain how the impairment satisfies the state requirement found on this application: (attach additional pages as necessary)

_____
_____
_____
_____
_____

Dr. Office Use Only:

Physician Signature_____ Date_____

Professional Title _____

Physician Name (print)_____Telephone Number_____

Affix Office Stamp Here: Address_____

City _____State_____Zip_____

Division Use Only:

Applicant meets the qualifications for this COR **Y** **N** ☐ **Need more information**

Region _____ Date:_____ Clerk Initials:_____

NOTES:_____
_____
_____
_____

For more information or additional consideration please contact: Kenneth Johnson (801) 538-4839